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Not in the Normal Way: Mothers' Experiences of Caesarian Section Delivery

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Abstract

This study explored the experiences of mothers who underwent cesarean section delivery (C-section). The study employed a qualitative-phenomenological research approach, and through snowball sampling, participants were determined based on having undergone a C-section from January 2022 to December 2024. Upon identification of the participants, a one-on-one interview was conducted using an interview guide. The interview answers that were gathered were subjected to descriptive thematic analysis, which yielded three themes: coming to grips with reality, emerging tolls of the undertaking, and gaining strength and moving forward. Under the first theme were two subthemes, feeling of pain, discomfort, and undertaking the process as a necessity of the moment; two subthemes for the second theme which were impeding mobility as co-existing and consequential and caring for oneself as an ordeal; and two subthemes for the third which were seeking a Higher Power's consolation and acknowledging available support system. It was concluded that the lived experiences of mothers who underwent caesarean delivery are characterized by a multitude of physical sensations and feelings which either prompted their decision to undergo the procedure or stemmed from the procedure itself. They also encountered challenges mainly from the aftermath of the operation limiting mobility, self-care, and nutrition and used support systems to cope. It is recommended that the results of the study be used to enhance nursing care plans in the delivery room for CS cases, especially so that nurses will have a better understanding of what patients of the procedure can go through and how support systems (including the promotion of spiritual health) can help in recovery.

Keywords: Caesarian Section Delivery, Experiences, Thematic analysis

Introduction

Mothers in the moment of delivering a child, face some of the most overwhelming experiences in their lifetime. The experience is even more authentic for those who have to reconsider the usual way of delivering a child because the circumstances are not favorable, and there is a risk of losing a life or two. Perhaps this will not present itself as a confrontation when a mother has been through one or two faultless childbirths, the likeliness of which is high if you underwent normal delivery. This is not, however, the case for those who had to go the less-taken and less safe route of Cesarean delivery, wherein those with experience/s shared emotional roller coasters (Lin & Xin, 2021) pain and discomfort, which made it challenging to resume expected activities after childbirth, and the worst, the fear of dying or losing their baby (Husby et al., 2019). With a shared feeling of being in a near-death experience, it is interesting that the tales of those who experienced Cesarean delivery do not always come across as worth telling because we see the survivors unscathed. With this study, however, their stories can be shared with an unknowing audience to better understand the experience and ultimately appreciate the value of life, which could have stemmed from an emotionally challenging, painful, and life-threatening experience.

Cesarean delivery, also known as a C-section, is a surgical procedure performed to deliver a baby through incisions made in the mother's abdomen and uterus. The operation is typically performed when a vaginal birth poses risks to the mother or baby or when complications arise during labor. Common reasons for a cesarean section include fetal distress, abnormal positioning of the baby, placental issues, or a previous cesarean delivery (Sung et al., 2024). It is the most common surgery done in the United States and it is estimated that 1.3 million women undergo this process every year (Sung & Mahdy, 2023).

In the Philippines, the 2022 National Demographic and Health Survey by the Philippine Statistics Authority (2023) indicates that the percentage of live births in the country assisted by a skilled provider increased from 62.0 percent in 2003 to 89.6 percent in 2022. Meanwhile, the percentage of births delivered via cesarean section was about 19.5 percent in 2022. By age, more women aged 35 to 49 years had undergone a cesarean operation during delivery (26.9 percent) compared to women aged 20 to 34 years (18.3 percent), and women below 20 years old (14.6 percent). In the Philippines, the utilization of CS has continuously surpassed the recommended maximum cutoff of 15%. This increased rate is associated with maternal age, educational attainment, family income, birth order, and

the timing of antenatal care visits. The socio-economic factors demonstrate socio-economic disparities in accessing CS services. Emphasizing the need for performing medically indicated CS can promote better maternal and child outcomes and reduce the rate of unnecessary CS deliveries. Prioritizing initiatives to provide equitable access to CS services is imperative (Felipe-Dimog et al., 2025).

Though the validity of undergoing CS is based on medical and practical considerations, some pregnant women will either go for the procedure or avoid it because of how they have formed conceptualizations and/or misconceptions of it. Kindelan (2022) cites six misconceptions among women about CS: (1) it is a minor procedure, (2) giving birth via C-section is a failure, (3) all C-sections are necessary, (4) expectant women cannot question their doctor about C-sections, (5) C-sections hurt, (6) C-section recovery is easy. Although these misconceptions are from American women, some are shared considerations in the Philippines when undergoing the procedure. Medical City (n.d.) cites a few preparations for those about to undergo the procedure, including educating oneself, planning for post-surgery care, following pre-operation instructions, and packing a hospital bag.

Since the majority of the components needed for performing a successful cesarean delivery are readily available (equipment, medication, and medical staff), empowerment is almost nearly left to the support of the patient's partner and family, which, as cited, is still being debated. Conducting this study will help provide useful findings that will deepen and widen a better understanding of women who underwent cesarean and consequently enhance the provision of the procedure, treatment, and recovery measures that will lessen or eliminate complications, as well as the appropriate empowerment and support they need to prepare those who will undergo the process and improve overall coping.

Literature Review

The Modern "C" Forms of Birthing

Technologically assisted reproduction is changing the traditional sequence and meaning of conception, labor and delivery. C-section can be considered one the earliest forms of modern birth technology. In many countries all over the world c-section birth rates are rising. In some countries, like Brazil or Taiwan, caesarean birth rates are skyrocketing up to 60%, because giving birth this way is considered to be fashionable. In the USA more than one million women, 1 in 3, give birth by caesarean every year. In 2007 the Belgian medical profession was very 'proud and delighted' because in 2007 the average c-section rates dropped from 17.5% to 17%. For many years the WHO is warning against the rising caesarean births. The WHO has stated that about 10 to 15% of all births should be c-sections. This raises the question about what factors play a role in rising c-section rates and in these differences.

There are multiple reasons for the rise of c-section rates. Factors that influence the growing c-section rates are: the growing average age on which women get there first baby: the older the woman the more c- sections; the reduction of the average number of children a fertile woman gives birth to: the fewer children the more c-sections; better insured woman get more c-sections; the higher the socio-economic status of the woman the higher the c-section rate; medical protocols like: once c-section always c-section, or breech is equal to c-section, or the growing rates of epidural anesthesia; electronic fetal monitoring giving cause to more 'false alarms'; more induction lead to more c-sections; multiple pregnancies as a result of IVF and other artificial reproductive techniques; growing health problems in women, f.e. diabetes and obesity; woman are (being made) more afraid to give birth vaginally; more prenatal stress is linked to more birth complications including c-sections; women are choosing more and more for 'the easy and comfortable way'; role models like media starts who choose a c-section as a 'lifestyle choice'; women and their partners want to keep the 'honeymoon vagina' intact; the larger the hospital the higher the c-section rates; the older the doctor the more c-sections; and the growing number of law suits against obstetricians; the c-section is supposed to protect the doctor, because they can then be said to have done everything they can to save the baby. Medical developments have made the procedure safer, especially with the introduction of the low-segmental technique. The safety of a caesarean is comparable to the safety of the vaginal route. But safety is not the primary reason for the widespread use of c-section. Social cultural, non-medical reasons seem to be of more weight than pure medical indications. The conclusion is that the growing caesarean birth rates are not only caused by clinical medical practice, but also by non-medical, cultural, psychosocial and socio-economic factors. More and more do market driven solutions drive birth decisions and do superstars act as a role model for elective c-sections. Instead of empowering women, -trusting their female instincts, feeling strong and comfortable on giving birth vaginally in the privacy of a quiet and safe environment -, women are being made anxious to give birth outside the hospital and more hospital births give rise to more c-sections. The rising rates of c-section births goes together with the medicalization of pregnancy and birth. There is a strange contradiction in medical practice: pregnancy and birth are more and more seen as a disease, while caesarean birth is seen a normal, routine healthy operation.

There seems to be a 'caesarean temptation,' that is to say the temptation to make the caesarean the most common way to give birth. The caesarean birth is no longer a rare rescue operation. Caesarean birth tends to become the norm, at least in some countries. The right to choose is becoming acceptable and we are entering the area of caesarean on demand. A pro-caesarean culture is spreading. In most industrialized countries, about 5% of all births

were caesarean sections in 1970. In the eighties this figure was more than twice. By 1985 the figure was 15-20% in a number of industrialized countries. The situation on rising c- section rates is even alarming in developing countries.

Medical risks and broadening diagnostic criteria.

C-sections can be life saving for both mother and child. This is the primary justification for c- sections. C-section has undoubted benefits for certain complications of pregnancy and birth. There is no discussion about these lifesaving c-sections, although we need to become more aware that the baby has to pay an emotional price for this way of entering the world, as we shall see later on. The discussion is about c-section deliveries for which there was no evidence-based necessity. C-sections have become a safe surgical procedure, although it remains a major abdominal surgery. The medical risks of c-sections are: complications with the anesthesia; complication by infections; post-surgery complications like peritonitis, embolism, pneumonia, infection of the scar, anemia; lower subsequent fertility; damage to the urinary bladder, causing incontinence; complications in breastfeeding; death of the mother and/or baby; more complication in the next pregnancy and birth. Even today about 1 to 2‰ of women giving birth by c-section die from or after c-section. This risk is 4 to 12 times higher than in vaginally childbearing. Death by c-section is extremely under documented. According to WHO c-sections do not reduce the rates of perinatal mortality. The increase in the number of operative deliveries will, at best, only have a very small impact on perinatal mortality rates

There has been an evolution in the diagnostic criteria for c-section. Now a distinction can be made between absolute indications and debatable indications (Odent, 2004). Absolute indications are: cord collapse, real placenta praevia, placenta abruption, a brow presentation, a transverse lie or shoulder presentation, cardiac arrest. Debatable indications: previous caesarean, failure to progress, cephalopelvic disproportion, foetal distress, fibroids and ovary cysts, breech presentation, twin birth, vulnerable babies (premature or small-to-date). In order to prevent more babies and later adults suffering psychologically from caesarean birth a critical evaluation of debatable diagnostic criteria is necessary. An example of this position is the medical policy in breech delivery.

Maternal reactions to caesarean birth.

There is a debate about the emotional scars of a caesarean birth. Some researchers suggest that the negative psychosocial effects of caesarean births can be significant and far-reaching for some women (Mutryn, 1993). Others found no evidence that elective caesarean section altered the odds of postnatal depression compared with planned vaginal delivery, neither does elective c-section protect against postnatal depression, nor does it prevent a 'baby blues' (Patel et al., 2005).

A distinction must be made between emotional effects of a planned 'elective' caesarean when the woman can anticipate the operation and decide how it shall be conducted, and on the other side an emergency c-section with no preparation. Different mothers seem to have different experiences and make different choices. It seems evident that women who 'choose' for a c-section delivery are more satisfied by the result and complain less about the disadvantages. However, according to reports by De Jong and Kemmler (2003) women who prepared for a natural birth and were not expecting a c-section often have complains like: not having given birth themselves; losing control over the birth process; not being a complete woman having failed to give birth vaginally and having ruined something precious like natural birth; mixed emotions: happiness because of the baby being delivered and sadness because of the way the baby was born; feelings of guilt; fears about the health and well-being of their babies. Oblasser, Ebner and Wesp (2008) interviewed and photographed 162 women who have given birth by c-section. Not only most women thought that the media minimize caesarean birth as a painless experience, but most of them also reported that the caesarean birth of their children was a disappointing, not natural, birth experience, that was necessary to save the lives of mother and child, but also a failure in motherhood that needs to be grieved.

Because c-section can be an extremely painful experience, often associated with feelings of being out of control and a lowered self-esteem, it is understandable that some women experience caesarean birth as a psychological trauma (Reynolds, 1997). Stress response symptoms include: intrusive thoughts about damaging effects of c-section, avoidance of hospitals and obstetricians, numbing of emotion and a sense of increased arousal. C-section mothers experience more post-traumatic stress symptoms than vaginally delivering women. Emergency c-sections (EmCS) have a deleterious effect on maternal well-being. Healthy pregnant women with a serious fear of childbirth appeared to be at greater risk. The degree of fear for childbirth seems to be the best predictor of the degree of maternal well-being after EmCS . Emergency c-section is often a traumatic experience for the mother with more symptom of post-traumatic stress disorder (Ryding, 1998). A disproportionately number of women who had a caesarean birth report symptom of postpartum depression, as compared to women who gave birth vaginally (Boyce and Todd, 1992; Brown, 1994). In the reports by Oblasser et al. (2008) almost half of the women experienced problems in the bonding process after c-section. Only about 50% of the women had seen the baby during the surgery. Due to the medical procedures the first body contact between mother and baby after birth was delayed in most c-section births for several hours. The importance of direct bonding after birth has been established for a long time, yet medical procedure does not seem to recognize this important moment of imprinting immediately after birth. In a f-MRI research Swain et al. (2007) found more activity in areas linked to motivation and emotions in those who had a

vaginal birth compared with c-section birth. The hormones generated by birth could explain the differences. During contraction of vaginal birth trigger the release of the hormone oxytocin. Undergoing a caesarean does not trigger the release of this hormone in the same way. Oxytocin plays a key role in shaping maternal attachment behavior. Swain and his colleagues conclude that variations in delivery conditions such as with caesarean section, which alters the neurohormonal experiences of birth, might decrease the responsiveness of the human maternal brain in the early postpartum (Swain e.a., 2007). In their Doula book Klaus, Kennell and Klaus (2002) that women that were physically and mentally supported during delivery by a doula and received tender loving care during delivery showed less need for pain killing medication, had more positive better feelings about their delivery, had better bonding relationships to their child, and showed less postpartum depression. This doula support and care is not possible during c-section procedures.

Methodology

Research Design

This study employed a qualitative-phenomenological research approach, which involves gathering qualitative data. Tenny et al. (2022) define qualitative research as exploring and providing deeper insights into real-world problems. Qualitative research gathers participants' experiences, perceptions, and behavior. It answers the "hows" and "whys" instead of how many or how much and could be structured as a standalone study, purely relying on qualitative data. Qualitative research, at its core, asks open-ended questions whose answers are not easily put into numbers, such as "how" and "why."

Qualitative-phenomenological is a qualitative research method that allows researchers to study how experiences, traditions, and culture shape ordinary, everyday practices. Phenomenology is rooted in the philosophical tradition developed by Edmund Husserl in the early 20th century, which his followers later expanded on at the universities in Germany. Husserl's ideas about how science should be conducted resulted in the development of a descriptive phenomenological inquiry method (Shorey & Ng, 2022), which is aligned with the naturalism doctrine that denies a strong separation between scientific and philosophical methodologies and rejects logical positivism's focus on objective observations of external reality (Freeman, 2021). the goal of descriptive phenomenology is to describe the universal essence of an experience as lived, representing the phenomenon's true nature (Shorey & Ng, 2022).

Participants

The participants for this study were post-cesarean section mothers who had been admitted for cesarean delivery within the period of January 2022 – December 2024. The specified period was set for a higher chance among the participants to recall their CS experiences. Nevertheless, this number was determined based on a saturation point for the responses needed, of which 12 were gathered. In addition, since a profiling section is included in the initial portion of the interview guide, the responses from the participants were chosen to allow for variations in their demographic backgrounds (age and educational attainment).

Research Instrument

A researcher-made data–gathering tool was crafted to gather the necessary data and address the study's objectives. It comprised a profiling section and an interview guide to detail the participants' experiences when they underwent

Caesarean delivery. Four questions made it to the final form of the interview guide. The questions were open-ended and allowed answers from the participants to be as detailed as possible.

Validity and Reliability

As an interview guide for gathering qualitative data, validity and reliability were established using Stahl and King (2020), citing Lincoln and Guba (1985), who discussed how validity and reliability are paralleled by the concept of trustworthiness in qualitative research. Lincoln and Guba argued that the concepts of validity and reliability employed in quantitative studies do not apply to their qualitative counterparts. Instead, establishing the concept of trustworthiness will suffice for the purpose. Trustworthiness covers four criteria: credibility, transferability, dependability, and confirmability. The actual research process covered these criteria and has served the purpose of validity and reliability.

The study has credibility or truth value as the data gathered were authentic accounts of real people. It also has transferability because the participants' experiences apply to other individuals who also underwent a C-section, and the other way around is accurate. The study also has dependability because the themes that emerged from the study came about because of consistency in the statements and responses of the participants. Lastly, the study is

confirmable because it is neutral in its conducting. The participants were allowed to speak their minds based on their experiences and were not given any imposition that might hinder or filter their answers to the interview.

Data – Gathering Procedure

The researcher prepared and sent letters to the participants soliciting their consent to participate in the study. Participants were identified based on recommendations from other participants for as long as they met the qualification for having undergone a C-section within the specified timeframe. The letter included the nature and purpose of the study, the nature of the respondents' role, especially to its success, and its potential to add to the bank of helpful information that can be put into action and contribute to the healthcare system. The content of the letter was discussed in detail and with emphasis on the participants' option to refuse or withdraw from the said study whenever they feel threatened or uncomfortable. The letters were duly signed and collected before the study's conduct to meet the ethical standards of research.

An in-person interview was conducted. The place and time of the interview were chosen to allow for the most comfortable set-up and interaction. The interview was conducted by giving the participant a copy of the questionnaire, which he/she will refer to as the researcher reads each question, and giving the participant time to think about their answers. The researcher recorded their answers with an accompanying audio recording for those who consented to recording the interview.

Data Analysis

Thematic analysis was used in this study, which involves fragmenting texts according to themes, coding small portions, and then collating them. Thematic analysis analyzes data related to opinions, thoughts, feelings, and other descriptive expressions. Thematic analysis allows researchers to look at a data set obtained through multiple qualitative sources and pull out the broad themes running through the entire data set to make meaning. In thematic analysis, the researcher will closely examine the data to identify common themes – topics, ideas, and patterns of meaning that come up repeatedly. A thematic analysis aims to identify themes, such as patterns in the data, that are useful in explaining a certain behavior and use these themes to address the research or explain something about a social issue (Rosairo, 2023). Thematic analysis is a method to analyze qualitative data. It involves the identification and reporting of patterns in a data set, which are then interpreted for their inherent meaning (Liebenberg et al., 2020; Xu & Zammit, 2020); these patterns can be found on the basis of understanding the meaning of keywords used by participants. This study referred to Braun and Clarke's method of reflexive thematic analysis first developed in 2006 and was contextualized in a paper by Byrne (2022).

After the interview, the researcher collated the interview guides with the written responses and made sure that all the responses were correctly transcribed. The researcher read the interview responses, which were matched with audio recordings for those who agreed to record the interview. Re-reading was also done to gain an overall impression of the data, preparing the researcher for the next step, coding. Responses were extracted from the actual thread of statements from the participants since it is not uncommon for them to digress from the interview's primary focus. Chunks of ideas were noted and isolated in a separate word document, which helped the researcher generate descriptions and/or categories describing the participants' experiences in undergoing a C-section. These generated categories were organized in a table for easy organization and presentation. From the generated themes, subthemes were identified, which were incorporated into the table with sample codes to validate them. Finally, the extracted results were presented with the researcher's interpretation and how they relate to findings from other studies exploring the same topic.

Ethical Considerations

As one of the important considerations for the study's successful conduct, meeting ethical standards when doing research was observed stringently. The respondents' consent to willfully engage in the study and the provision of security and confidence that all data and information gathered from them were to be kept private/confidential were given sufficient attention.

About the above-mentioned concerns, the researcher prepared and sent letters to the respondents soliciting their consent to participate in the study. The letter included the nature and purpose of the study, the nature of the respondents' role, especially to its success, and its potential to add to the bank of helpful information that can be put into action for the benefit of the health sector. The content of the letter was discussed in detail and with emphasis on the respondents' option to refuse or withdraw from the said study whenever they feel threatened or uncomfortable. The letters were duly signed and collected before the study's conduct to meet the ethical standards of research.

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Result and Discussion

Table 1:

Themes, subthemes, and codes extracted from interview excerpts

Themes	Subthemes	Significant Statement
COMING TO GRIPS WITH REALITY	Feeling of Pain, Discomfort, and Unease	*pwerti gid nga pasakit sang akon nga tyan. Gadugang ang sakit kung magbusog na akon tyan, nga daw feeling mo pati emu pagginhawa daw mabugto man.*
		It was (quite) a challenging and traumatic experience. I experienced the most painful labour pains that I cannot tolerate and I'm not comfortable.
		Sakit nang puson, sakit sa balakang sakit nang paa, as in mapapaiyak ka talaga,
	Undertaking of the Process as a Necessity of the Moment	*Hirap na kasi ako sa bata kung ipipilitn ko talaga hindi ko kakayanin,Eh nawalan na ako noong una baka maulit nmn*
		Nag decide ko kay according sa Doc kay sa edad ko kag twins sya, teh wala ko choice teh go.
		Wala naman ko choice kay indi man maggwa ang bata kung indi ko pag CS kay hambal sang Doc.
		Previous CS kag Kapid akon bata kag indi ko pwedi pabataon Normal
EMERGING TOLLS OF THE UNDERTAKING	Impeding Mobility as Co-existing and Consequential	*Sang ara nako sa bed nabatyagan ko na okay na sige nako hibi kay indi nako kaagwanta, indi ko na magiho kabudlay*
		Pagkatapos sang akon CS mas challenging pagid sya kay syempre indi ka gid kagiho but need mo mgpabreastfeed sa baby mo, kabudlay ky ultimo gamay nga giho kasakit sa tinahian mo biskan my binder kpa
		…indi ka kagiho nga daw robot ka
	Caring for Oneself as an Ordeal	*Kung CS ka kay 8hrs na amo kapa makainom tubig, kaginhawa nako pero sakit dyapon ang tahi. Subong lang ka kapid bata, mafamily planning ngid ko*
		limited (emu giho) ang emu kaon, indi pwede mg inom tubig kay antis mga 2 days kay syempre gutom na amu na eh tapos ang pain indi ka mayo kagiho tungod kasakit pero kinahanglan mo magiho gid para giho mga tinae mo eh
		After CS, budlay pagid eh ang emu giho limit ang emu ano pilas kinahanglanon mo nga indi mag anu mgbuka, sa kaon mo nang pagkatapos mo CS indi kpa kakaon indi kainom tubig, uhaw tuyo kapoy jpon emu mabatyagan
GAINING STRENGTH AND MOVING FORWARD	Seeking a Higher Power's Consolation	*Pray lng kay lord; Pasasalamat nalang ky Lord.*
		tanan nga pag ampo sa Ginoo nga ubayan yah lang gid ako kg ang ako bata nga maging safe kami nga duwa.
		During CS I surrendered myself through my faith and prayers to GOD, that he will guide me and never leave me during CS operation.

	Acknowledging Available Family and Social Support	*That time ang gina pinsar ko nalang gid is all the goods for the baby even sang time nga gapaprenatal ako*
		Buti nga andyan si nanay binabantayan kaming dalawa, kahit paano inaassist na kaming dalawa
		Sa anu man eh bulig sang emu pamilya indi ka man kagiho nga ikaw lang kapin pagid ko mg CR ka esp kung ara kna sa balay mo.

Theme 1: Coming to Grips with Reality

This theme encompasses two subthemes: "feeling of pain, discomfort, and unease" and "undertaking of the process as a necessity of the moment."

Subtheme 1: Feeling of pain, discomfort, and unease

A commonly shared anecdote of the mothers who underwent C-section was the high level of pain and discomfort, which for some was described as intolerable. Based on the responses of the informants, they felt physical pain due to labour and the operation, injection of anaesthesia, numbness, and feeling of fatigue, panic, and anxiety.

Confirming these findings, some of the responses were:

"It was (quite) a challenging and traumatic experience. I experienced the most painful labour pains that I cannot tolerate and I'm not comfortable." [Participant 1]

"pwerti gid nga pasakit sang akon nga tyan. Gadugang ang sakit kung mgbusog na akon tyan, nga daw feeling mo pati emu pagginhawa daw mabugto man…" ("My stomach felt very painful especially when it contracts; you feel like you will also lose your breath.") [Participant 4]

"Sakit nang puson, sakit sa balakang sakit nang paa, as in mapapaiyak ka talaga." (My lower abdomen, my pelvis, and my legs were hurting.") [Participant 8]

Based on the accounts of the informants, the pain and discomfort they felt were some of the reasons why they were urged to undergo the procedure. For some, the feelings led to unease and anxiety, especially for those who never knew what to expect if ever they continue to experience the pain. Others narrated that the pains and discomfort were more pronounced after the procedure, most especially when the effect of the anesthesia had dissipated. The pain experienced among mothers post-cesarean is one that can be expected since the numbing effect of the anesthetics was gone. In many studies about the experiences of mothers who have undergone a C-section, post-CS pain was described as unbearable, an experience that in obstetrics is one of the most reported problems post-CS.

Consistent with the findings of Meric et al. (2019) also share experiences among their participants about (abdominal pain) after the operation. According to Duran & Vural (2023), mothers experience more pain, breastfeeding problems, worsened sleep, quality and comfort, anxiety, delayed recovery, and prolonged hospitalization in the post-cesarean period. Mothers mostly experience problems with breastfeeding and personal nutrition during the post-CS period.

In a quantitative study by Hussen et al. (2022), several important findings regarding post-CS pain were highlighted. The magnitude of postoperative pain after a cesarean section was 89.8%. In addition, about 84.2% reported moderate to severe pain 24 hours after surgery. Likewise, the duration of the procedure was significantly associated with postoperative pain. Lastly, the anesthesia type used was found to be significantly associated with postoperative pain.

As a whole, the experiences of mothers who underwent a C-section can be described a painful and discomforting. Regardless of whether it is prior to, during, or after the procedure, pain, and discomfort are concepts that are easily associated with a CS section. Nevertheless, the highlights of the experience are after the actual procedure, which can be expected based on testimonies of other mothers or what the logic of the medical procedure will tell.

Subtheme 2: Undertaking of the process as a necessity of the moment

For many child-bearing mothers, undergoing vaginal delivery is the most preferable and according to expectations. According to Sung et al. (2022), several factors can preclude a safe vaginal delivery, necessitating a cesarean delivery. Vaginal delivery is in fact considered the usual way of giving birth. Certain conditions, however, will hinder

the possibility or, if not, will lessen the success and survival rate of either or both mother and child if normal delivery is insisted during circumstances that call for a C-section. For some, the decision is made because that is what they prefer, while some simply are not left with the choice of giving birth the normal way because of underlying medical conditions, past pregnancies, or overall labor experience, both past and present. As Meric et al. (2019) stated, having a positive or negative experience of labor affects the method of delivery women select for their subsequent pregnancy.

The most recurring reasons why the participants of this study underwent CS are: pregnancy history or previous experiences of having a C-section, raised blood pressure and bleeding, and the overall feeling of not being able to contain their situation, (i.e. pain, prolonged labor with no development, or the need to just be able to finally give birth, needing to give birth to twins). Some of the participants' statements on what necessitated them or why they have to undergo C-section were:

"Hirap na kasi ako sa bata kung ipipilitn ko talaga hindi ko kakayanin. Eh nawalan na ako noong una baka maulit naman…" ("I just really found it difficult with the child I was carrying. I know that if I had to bear with it, I will not stand it. I already lost a child in my womb before.") [Participant 8]

"Nang decide ko kay according sa Doc kay sae dad ko kag twins sya, teh wala ko choice teh go." ("I did not have a choice, I had to go with it because oif my age and because I was to deliver twins.") [Participant 6]

"Previous CS kag Kapid akon bata kag indi ko pwedi pabataon normal." ("I already had a history for CS and I have twins. I really cannot really do normal delivery.") [Participant 5]

The conditions that necessitate a C-section are numerous, although they can fall under any of the following indications, according to Sung et al. (2022): maternal indications, uterine or anatomic indications, and fetal indications. Louis (2023) cites that the most common indications for primary cesarean delivery include labor dystocia, abnormal or indeterminate fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the primary cesarean delivery rate will require different approaches for these indications and others. Increasing women's access to nonmedical interventions during labor has also been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are examples of interventions that can help to safely lower the primary cesarean delivery rate.

For a number of the participants in this study, undergoing a C-section can be considered as unplanned because they did not have it in mind, but instead what the circumstances called for, while for some, it might just be as expected due to previous birth histories, or their overall knowledge of their health status. Regardless of what predisposed the participants to the procedure, the findings of this study are within what the medical literature presents. That is, a C-section is to be carried out if normal delivery is not favorable. This further highlights the overall goal of the procedure and why it has been an option among birthing mothers, because it is geared towards successful and safer child delivery despite its associated complications and after-effects.

Theme 2: Emerging Tolls of the Undertaking

This theme describes the accompanying downsides of undergoing a CS before, during, and after the procedure. This theme includes two subthemes –impeding mobility as co-existing and consequential and caring for oneself as an ordeal.

Subtheme 1: Impeding mobility as co-existing and consequential

Aside from post-CS pain and discomfort, which in and of itself is limiting, other things and experiences partly disabled the participants physiologically and physically. Some reported difficulty of resting properly (due to pain and associated discomfort), while others reported the most commonly prohibited acts of being able to eat and drink water. Due to the operation's physical tolls, mobility has also been an issue. These challenges were narrated by the participants like the ones that follow:

"Sang ara nako sa bed nabatyagan ko na okay na sige nako hibi kay indi nako kaagwanta, indi ko na magiho kabudlay." ("When I was in the bed and was feeling a bit okay I started crying because I cannot endure it anymore. I cannot move, it was difficult.") [Participant 6]

"Pagkatapos sang akon CS mas challenging pagid sya kay syempre indi ka gid kagiho but need mo mgpabreastfeed sa baby mo, kabudlay ky ultimo gamay nga giho kasakit sa tinahian mo biskan my binder kpa." (After my CS, it was even more challenging because I cannot move, yet you need to breastfeed. It was hard because the smallest movement hurt due to the stitches even if you have a binder.") [Participant 4]

"…indi ka kagiho nga daw robot ka…" (You cannot move as if you are a robot). [Participant 5]

Consistent with the findings of Duch et al. (2024), they specifically cited mothers' challenges in moving from the hospital to their homes. In particular, pain associated with specific activities was a challenge, particularly getting from a lying to a sitting position, and getting out of bed. Additionally, despite verbal information from healthcare staff regarding mobilization and rehabilitation, many patients remained uncertain about their physical activity limitations and requirements, especially how much they should refrain from lifting. The patients also expressed a wish for a rehabilitation plan. Many felt that they had not received sufficient information regarding mobilization and rehabilitation, which felt disempowering. Duran and Vural (2023) also included mobilization as one of the most important problems in mothers with CS.

The physical tolls of a C-section, especially after the operation, are expected outcomes. The reason why the majority will prefer normal delivery does not only prove logical but also a practical decision. Patients who undergo a C-section are more prone to post-operation complications such as infection, hemorrhage, and physical injuries (particularly to the pelvic organs). The patients are also expected to have a prolonged recovery period compared to those who undergo vaginal delivery (Berghella, 2024).

With the awareness that a C-section involves physically demanding procedures, it is expected that part of the after-effect will be the limitation of one's ability to function physically. The findings of his study have validated this challenge based on the participants' statements about their struggles with what they can do especially without any assistance. As with the association of a C-section to pain and discomfort, "physically limiting" is also one that can be used to describe the experiences of women who underwent the procedure.

Subtheme 2: Caring for oneself as an ordeal

"…pagkatapos mo CS indi kpa kakaon indi kainom tubig, uhaw tuyo kapoy jpon emu mabatyagan." ("After you undergo CS, you cannot eat or drink water. Thirst, lack of sleep, and tiredness; these are all you feel.") [Participant 3]

"…limited (emu giho) ang emu kaon, indi pwede mg inom tubig kay antis mga 2 days kay syempre gutom na amu na eh tapos ang pain indi ka mayo kagiho tungod kasakit pero kinahanglan mo magiho gid para giho mga tinae mo eh…" ("Your movements are limited; you cannot drink water two days after. I was also hungry and you cannot easily move due to the pain, although you need to so that you can feed yourself.") [Participant 7]

"Kung CS ka kay 8hrs na amo kapa makainom tubig, kaginhawa nako pero sakit dyapon ang tahi. Subong lang ka kapid bata, mafamily planning ngid ko." ("If you underwent CS, you can only eat and drink water after 8 hours. I was able to breath better but the stitches still hurt. It was only this time that I get to have twins and I'm thinking of doing family planning.") [Participant 4]

One of the participants' most shared accounts is the limitation to food and water, which was mostly not allowed (immediately moments after the procedure). Duran and Vural (2023) enumerated some of the postpartum period challenges among women who underwent a C-section, such as sleep and rest problems, bathing (hygiene/self-care), and nutrition. Martinez (2024) from MedLine Plus indicated that post-operation, the patient may be asked to only eat ice chips or take sips of water until the provider is certain the patient will not likely have hefty bleeding. The mother requires plenty of rest and a strict diet to recover from the procedure. During the first few weeks following the C-section, the mother should be thoroughly monitored and aided in recovering mentally and physically from the stress of the delivery (Care Hospitals, 2024).

As to why the patients shred the account of being limited in their food and water intake after the procedure, however, does not find any up-to-date backing. Based on an old study from 2002 by Mangesi and Hofmeyr, however, there is much variation in policies about when women are allowed to eat or drink after caesarean section. In some hospitals, women are not allowed to have food or fluids for more than 24 hours after the operation, in the belief that it might take a while for the bowels to settle down after abdominal surgery. However, caesarean section may not disrupt bowel function at all. The review found that the evidence from trials does not justify withholding food and drink after an uncomplicated cesarean section. There is some evidence, although not strong, that early food and drink might speed bowel recovery.

Nevertheless, a well-planned diet is essential to the post-cesarean care plan. With its associated procedures, patients can lose considerable amounts of fluids and blood, which clearly needs to be replenished and attended to. Healthy and nutritious foods such as protein—and calcium-rich foods, whole grains, vitamins and minerals, and iron supplements are encouraged. According to Care Hospitals (2024), CS patients would also have to avoid foods such as spicy foods and carbonated drinks.

The findings of this study validated shared experiences among other mothers who underwent CS delivery regarding their post-operation challenges affecting self-care and nutrition. From the participants' statements, CS experience restricts mobilization and physical enablement and one's ability to take care of the self. This also further relates to and confirms the need for support among CS patients, either by a partner, a family member, or a healthcare provider, knowing that there is a stage in their CS journey that makes it nearly impossible for them to look after themselves.

Theme 3: Gaining Strength and Moving Forward

This theme emerged after identifying two recurrent subthemes about what made coping among the participants easy and tolerable after the procedure. The subthemes were: seeking a Higher Power's consolation and acknowledging available support system.

Subtheme 1: Seeking a Higher Power's consolation

For the participants, prayer, belief in God, and spirituality were major highlights of how they coped with their C-section experience. Prayer and asking for strength from God or a higher spiritual being were present in nearly all of the participants' accounts. Whether they had a different source of support, such as from a partner or family, God was one that came up in their statements.

"Pray lng kay lord; Pasasalamat nalang ky Lord." ("Just pray to the Lord and give thanks.") [Participant 8]
"tanan nga pag ampo sa Ginoo nga ubayan yah lang gid ako kg ang ako bata nga maging safe kami nga duwa…" ("I had to ask for the Lord's mercy and guidance so that my child and I will be safe.") [Participant 2]

"During CS I surrendered myself through my faith and prayers to GOD, that he will guide me and never leave me during CS operation." ("During CS, I surrendered myself through prayers to God that He will guide me and never leave me.") [Participant 1]

Though science and religion are sometimes viewed as two distinct realms, having spirituality and some scientific approach combined yields far better outcomes than having just one or the other. For instance, although medicine is broadly viewed as scientific in its approaches, considering spirituality can enhance specific processes such as recovery from medical conditions, surgeries or as an integrative therapeutic component. Spirituality involves examining how we relate to the world around us and how we commune with our own sense of the divine. There is no 'right' way to be spiritual; spirituality and religion do not have to be synonymous. At its core, spirituality is about what speaks to you, enables you to find meaning and purpose in life, and is a pathway to connect with power(s) that are bigger than you (Herren Wellness, N.D.). In promoting spirituality, the strategy of religious adjustment is an important source of coping with chronic diseases. It helps maintain and enhance the patient's self-esteem, creates a purposeful and meaningful life, and increases psychological comfort and hope (Shahsavari Bami et al., 2020).

A growing body of research suggests that spirituality and faith can significantly impact health outcomes. Studies have shown that individuals who engage in spiritual practices or hold strong religious beliefs exhibit better coping mechanisms, lower levels of stress and improved overall well-being (Irsay et al., 2024). Research has revealed that people's spiritual beliefs and practices influence each other in complex ways that make focusing on the physical body alone, especially during periods of illness, incomplete and less effective than might otherwise be possible (Ogbuji, 2019). Furthermore, Ogbuji cites that while the word spirituality goes further and describes an awareness of relationships with all creation and an appreciation of presence and purpose that includes a sense of meaning, patients and family members are frequently aware of their spiritual needs during hospitalization, want professional spiritual attention to those needs, and respond positively when spiritual attention is given.

Though not limited to patients of C-section, the participants' spirituality has indeed provided them with the necessary support to get through the challenges of what they undertook. From their statements, they have called for guidance and help from a higher being through their journey (before and after the procedure) indicating their deeply rooted spiritual beliefs. The actually workings of their prayers may not be observable but for the purpose of being able to survive and get through a procedure such as a C-section and all its implied aftermath, the participants made it through with their faith.

Subtheme 2: Acknowledging available support system

For the participants, having their partner and/or family by their side providing support and comfort helped them get through the challenges and adverse effects of undergoing a C-section. Although not all of them had their partners to support them (for reasons of separation or the husband being at work), having a family member or even an in-law was a big help. Many of the participants also cited their newborn as their source of strength and willingness to recover, or their children in general (for those who did not give birth to their first-born through a C-section). Some of the accounts of the participants were as follows:

"That time ang gina pinsar ko nalang gid is all the goods for the baby even sang time nga gapaprenatal ako." ("During that time, I only though of everything that will be good for my baby, even during the time that I was having my prenatal consultations.") [Participant 6]

"Buti nga andyan si nanay binabantayan kaming dalawa, kahit paano inaassist na kaming dalawa." ("It was just fortuntate because I had my mother who was assisting me at bedside.") [Participant 8]

"Sa anu man eh bulig sang emu pamilya indi ka man kagiho nga ikaw lang kapin pagid ko mg CR ka esp kung ara kna sa balay mo." ("It is needless to say that I was able to cope because of my family's help. You can't just really move on your own especially when you have to go to the comfort room.") [Participant 7]

As a mother, seeing and bonding with one's newborn especially one that was delivered through a C-section can become a reward to look forward to. Although not all mothers will readily bond with their neonates due to the need for recovery, there were those who saw their neonates as a rightful reward for the pain they have to go through especially when the child is healthy. There are reported benefits for both the newborn and the mother of early skin-to-skin contact. Early skin to skin has been associated with increased rates and duration of breastfeeding and a decrease in maternal anxiety and postpartum depression. There were some whose partners being with them and making decisions with them in relation to the procedure made the whole journey more tolerable. One of the most commonly cited sources of support however, were mothers of the participants. Regardless of the support system, having one allows for better and faster recovery. According to Duch et al. (2024), despite the challenges faced by mothers who underwent a C-section, having a partner's support, especially with other children to care for, was helpful.

Although not directly related to post CS recovery, any experience that can be traumatic and anxiety-filled is aided and makes recovery better with a support system. Calhoun et al. (2022) states that social support is well-established as a major protective factor following potentially traumatic events. Likewise, social support has demonstrated numerous protective effects, from buffering risk for negative psychological outcomes to enhancing treatment. Group-based intervention can also be useful for trauma healing especially that mothers who underwent a C-section can be subject to post-traumatic stress disorder (PTSD) as Grisbrook et al. (2022) cites that there is an association between C-section births and PTSD. Griffin et al. (2023), cites group-based interventions can offer an effective way to reduce PTSD symptom.

With the understanding that C-section births have physical and emotional tolls, a support system of any form will help mothers with C-section experience recover faster. Aside from the actual support they are getting from the people around them, their relationships with these people are also enhanced and positively affected as part of the process of being in a supporting relationship.

Conclusion and Recommendation

Based on the findings of the study, it can be concluded that the lived experiences of mothers who underwent caesarean delivery are characterized by a multitude of physical sensations and feelings which either prompted their decision to undergo the procedure or as stemming from the procedure itself. They also encountered challenges which were mostly from the aftermath of undergoing the operation limiting mobility, self-care, and nutrition. As with any challenging moment in anyone's life, the mothers who underwent a C-section had their own sources of support that helped them cope with their experience which were mainly from faith and spirituality and social and family support.

Considering the findings of the study, it is recommended that experiences of those who underwent a C-section be used and incorporated in family planning talks or drives. With this, those who would want to have pregnancy can look ahead into the possibilities of what they might experience in the event that normal delivery is not warranted for their own pregnancy, providing them with the necessary mental, physical, and emotional requirement for the procedure. Findings of this study may also be used to enhance nursing care plans in the delivery room for CS cases especially that nurses will have a better understanding of what patients of the procedure can go through and how support systems (including the promotion of spiritual health) can help in recovery.

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